COMMENT

A case of lymphatic leukemia was complicated by chylous ascites, which was removed by paracentesis and did not reaccumulate for more than two months after x-ray therapy. Subsequently it recurred repeatedly, and autopsy showed obstruction of the thoracic duct by leukemic infiltration.

Stanford University School of Medicine.

FAULTY POSTURE CONTRIBUTING TO GASTRIC AND DUODENAL ULCER

By FREDERICK J. WALTER, M.D.
San Diego

THE writer has observed, over a period of years in medical practice, that gastric and duodenal ulcers occur more often in persons who sit a great deal, either at a desk or in faulty posture reading. The habit of sitting on the sacrum, rather than erect, is very common. This faulty posture, semi-reclining, pushes the costal arch inward, compressing the lesser curvature of the stomach and the cap of the duodenum, producing ischemia. Ischemia of the mucous membranes of the organs, with plenty of hydrochloric acid, would favor ulcer by allowing the bloodless tissue to digest its surface with resultant ulceration. It seems to me to be highly desirable that prolonged pressure should be avoided under the liver in this area during digestion. The frequency of ulcer in the lesser curvature of the stomach and the upper one-third of the duodenum would bear out this hypothesis.

It has also been my observation (both as a victim and with patients) that sitting erect and taking frequent deep breaths, if continued sufficiently long, has relieved the burning, gas, and distress.

I offer this as a most plausible contribution to the etiology, direct or indirect, to gastric and duodenal ulcer.

Bank of America Building.

ACUTE APPENDICITIS ASSOCIATED WITH ACUTE MECKEL'S DIVERTICULITIS

By P. M. HUNTER, M.D.
AND
E. F. KEHR, M.D.
Carmel

THE occurrence of acute inflammatory processes of Meckel's diverticulum, especially in children, is too well known to require recapitulation. In a symposium on "The Acute Abdomen," Miller and Wallace [1] have reviewed the literature on the anatomy and pathology of Meckel's diverticulitis, and have stressed the importance of searching for this condition when the appendix is not found to be acutely inflamed.

In our search of the literature we have not found a report of the association of Meckel's diverticulum and the vermiform appendix, each in an acutely inflamed condition sufficient to give rise to the acute abdominal symptoms and at the same time each having a small area of surrounding intestinal and peritoneal inflammation in no way associated with the other.

REPORT OF CASE

R. C., male, aged 32, had acute pain in the abdomen three days before admission to the Peninsula Community Hospital, which he attributed to indigestion due to hasty eating and fatigue from overwork. He was conscious for years of a small, annoying pain in his lower right abdomen, and felt that he "might have an appendix." On the evening before admission, he experienced very acute generalized abdominal pain, nausea and vomiting. In the morning, while at work, he called one of us. Examination revealed: Temperature, 100.4 degrees; pulse, 90; respiration, 16. The upper respiratory tract was negative. Lungs were clear and resonant, and the heart normal. There was moderate rigidity of the lower abdomen, especially of the lower belly of the right rectus. Pain only on deep pressure over McBurney's point. Rectal examination was negative. The leukocyte count was 26,500, with 82 per cent polymorphonuclear neutrophyllic cells. The patient was immediately admitted to the hospital for surgery, with the diagnosis of acute appendicitis.

After spinal anesthesia, a McBurney incision was made and the rectus retracted. As the peritoneum was opened a slight amount of serous fluid exuded. After placing the retractors, a thumb-like projection was seen through the opening. This was a diverticulum about seven centimeters long, two centimeters in diameter at its base and attached to the small bowel on its antimesenteric border. It was exceedingly inflamed in its proximal half and dark, hemorrhagic-black at its tip. No opening could be found. After ligating, excising and burying the stump with a purse string suture, we found it was located about one meter from the ileocecal junction. The surrounding ileum was moderately injected in an area of about three inches. The appendix was then located and found to be markedly swollen, about ten centimeters long and curved upon its tightened mesentery. There was great engorgement of its blood vessels and reddish-black in its distal portion. It was removed in the usual manner and closure was made without drainage. The patient, discharged from the hospital on the eighth day, made an uneventful recovery.

COMMENT

We are aware that, had the diverticulum not exposed itself immediately upon spreading the incision, we would have been content, having removed the acute appendix, and would probably have been acutely embarrassed at a later time with recurrence of symptoms remarkably simulating the appendicitis. Likewise, the hemorrhagic portion of the diverticulum might have been a peptic ulcer,[2] although no perforation could be found, and might have produced disastrous postoperative results had it been overlooked. This occurrence should stress the importance of further abdominal exploration, regardless of one's having found sufficient pathology to account for the surgical condition, since the percentage of diverticuli is from one to three per cent.[3]

Ocean Avenue.

1 Miller and Wallace: Meckel's Diverticulum in Acute Abdominal Emergencies, Annals of Surgery, 98:713 (Oct.), 1933.

2 Aschner and Karelitz: Peptic Ulcer of Meckel's Diverticulum, Annals of Surgery, 91:573 (April), 1930. Cobb: Annals of Surgery, 94:251 (Aug.), 1931.

3 The Practitioner's Library of Medicine and Surgery, 4:577. D. Appleton, 1935.